CABINET FOR HEALTH SERVICES

DEPARTMENT FOR MEDICAID SERVICES

MEDICAID REIMBURSEMENT MANUAL FOR HOSPITAL INPATIENT SERVICES

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Department for Medicaid Services
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Section 100. INTRODUCTION

A cost-related, prospective payment system for hospitals providing inpatient services for Title XIX (Medicaid) recipients, to be reimbursed under the Kentucky Medicaid Program (program) of the Department for Medicaid Services (department), is presented in this manual. If not otherwise specified, this system utilizes allowable cost principles of the Title XVIII (Medicare) Program. This payment method is designed to achieve three major objectives:

(1) to assure that needed inpatient hospital care is available for eligible recipients and indirectly to promote the availability of this care for the general public,

(2) to assure program control and cost containment consistent with the public interest, and

(3) to provide an incentive for efficient management.

Under this system, payment shall be made to hospitals on a prospectively determined basis for the total cost of inpatient care with no year-end cost settlement required. The basis of this prospective payment shall be the most recent Medicaid cost report (HCFA-2552) available as of November 1 of each year, trended to the beginning of the rate year and indexed for inflationary cost increases which may occur in the prospective year.

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In addition, a maximum upper limit shall be established on all inpatient operating costs exclusive of capital costs and professional component costs. For purposes of applying an upper limit, hospitals shall be peer grouped according to bed size with allowances made in recognition of hospitals serving a disproportionate number of poor patients. Another feature of the prospective system is a minimum occupancy factor applied to capital costs attributable to the Medicaid program.

If unaudited data is utilized to establish the universal rate, the rate shall be revised when the audited base year cost report is received from the fiscal intermediary or an independent audit firm under contract with the Department for Medicaid Services.

The payment system is designed to provide for equitable payment levels for the various peer groups of hospitals, and will directly result in the use of rates that are reasonable and adequate for efficiently and economically operated hospitals while providing services in conformity with applicable state and federal laws, regulations, and quality and safety standards.

Section 101. PROSPECTIVE RATE COMPUTATION

The prospective system is based on a universal rate year which is set for all hospitals using the most recent cost report data available as of November 1 of each year, trended to the beginning of the rate year and indexed (adjusted for inflation) for the prospective rate year. Rates based on unaudited data shall be revised upon receipt of the audited base year cost report from the fiscal intermediary or an independent audit firm under contract with the Department. Prospective rates include both inpatient routine and inpatient ancillary costs and shall be established taking into account the following factors:

(a) Allowable Medicaid inpatient cost and Medicaid inpatient days based on Medicare cost finding principles shall be utilized. Medicaid inpatient operating costs, excluding Medicaid inpatient capital costs and Medicaid professional component costs, shall be trended to the beginning of the rate year. The Medicaid inpatient capital cost is later used in determining a capital cost per diem. The Medicaid inpatient professional component costs shall be trended to the beginning of the rate year separately from the inpatient operating costs.

(b) Medicaid inpatient capital costs based on Medicare cost finding principles shall be utilized except that Medicaid inpatient building and fixtures depreciation cost is defined as sixty-five (65) percent of the amount reported for building and fixtures.

(c) Allowable Medicaid inpatient operating costs, excluding those fixed costs associated with capital expenses and professional component costs, shall be increased by the hospital inflation index to project current year inpatient operating costs.

(d) A Medicaid inpatient operating cost per diem shall be computed utilizing the Medicaid inpatient operating cost and Medicaid inpatient days.

(e) An upper limit shall be established on inpatient operating costs at the weighted median inpatient cost per diem for hospitals in each peer group, except as otherwise specified in Section 102. For purposes of applying n upper limit, hospitals shall be peer grouped according to licensed bed size. The peer groupings shall be: 0-50 beds, 51-100 beds, 101-200 beds, 201-400 beds, and 401 beds and up. Peer grouping shall be based on the number of Medicaid licensed hospital beds at the time of rate setting.

(f) A Medicaid inpatient capital cost per diem shall be computed using Medicaid inpatient capital costs and Medicaid inpatient days. Allowable Medicaid capital costs shall be reduced if the minimum occupancy factors are not met by artificially increasing the occupancy factor to the minimum factor, and calculating the capital costs using this minimum occupancy factor.

1. A sixty (60) percent occupancy factor shall apply to hospitals with 100 or fewer beds.

2. A seventy-five (75) percent occupancy factor shall apply to hospitals with 101 or more beds.

(g) Allowable Medicaid professional component costs shall be increased by the inflation index (DRI/McGraw-Hill Hospital Market Index) to project current year professional component costs. A Medicaid inpatient professional component cost per diem shall be computed utilizing the Medicaid inpatient professional component costs and Medicaid inpatient days;

(h) For acute care hospitals the allowable rate growth from the prior rate year

to the new rate year shall be limited to not more than one and one-half times the Data Resources, Inc. (DRI) inflation amount for the same period; limits shall be applied by component (operating and capital cost components only); rate growth beyond the allowable amount shall be considered unallowable for rate setting purposes.

(i) The prospective inpatient rate shall be the sum of the allowable inpatient operating cost per diem, the allowable inpatient capital cost per diem, and the allowable professional component per diem.

(j) If a review or appeal decision results in the revision of a rate, any additional operating cost not included in the base year cost report shall be offset by the amount allowed for trending and indexing in the following manner:

(1) If the cost increase is incurred prior to the rate year in question, the additional operating cost shall be offset by the amount allowed for trending and indexing.

(2) If the cost increase was incurred during the rate year in question, the additional operating cost shall be offset by the amount allowed for indexing.

For the rate period beginning January 1, 1997, the rates shall be the rate in effect for January 1, 1996 with the operating and professional components of the rate indexed forward for the 1997 rate period. Additionally, there shall be an add-on to the rate, computed as fifteen (15) percent of the amount between the lessor of the operating cost per diem and the maximum operating per diem as limited by the rate of increase control (1 ½ times the DRI) that is reflected on the 1996 individual Medicaid hospital rate notices. The capital component shall not be indexed, however, the capital component of the rate shall be the amount computed for capital cost in the 1996 individual Medicaid hospital rate notices, excluding the application of the rate of increase control (1 ½ times the DRI). The indexing factor to be used for the rate setting process for the period beginning January 1, 1997 shall be the inflation factor prepared by DRI for the same period.

Section 102. ESTABLISHMENT OF UPPER LIMIT

An upper limit applicable to all inpatient costs, except capital costs and professional component costs, shall be set at the weighted median cost for hospitals in each peer group, with the exception of hospitals serving a disproportionate number of indigent patients. (See Section 102B regarding hospitals determined to meet disproportionate share requirements).

Rehabilitation hospitals and acute care hospitals providing only rehabilitation services shall be exempted from operating upper limits.

General procedures for setting the upper limit shall utilize cost reports available as of November 1 of each year for all hospitals, allowable Medicaid inpatient cost, excluding those fixed costs associated with capital expenses, and professional component cost shall be trended to the beginning of the prospective rate year. The trending factor shall be established using the Date Resources, Inc., average rate of inflation applicable to the period being trended. The trending factor thus determined shall be utilized to establish the allowable Medicaid inpatient cost basis for indexing.

The cost basis shall then be indexed for the prospective rate year to allow for projected inflation for the year. The result represents the Medicaid inpatient allowable cost basis for rate setting, which is then converted to a per diem cost

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utilizing the latest available Medicaid inpatient bed day statistics for each hospital.

For purposes of applying an upper limit, hospitals shall be peer grouped according to licensed bed size. The peer groupings for this payment system shall be as follows: 0-50 beds,51-100 beds,101-200 beds, 201-400 beds, and 401 beds and up.

The hospital inpatient operating cost per diems shall be arrayed from lowest to highest by peer group. Hospitals exempted from operating limits shall not be included in the array(s). Newly constructed hospitals and newly participating hospitals shall be excluded from the arrays until a cost report that contains twelve (12) full months of data is available. The median cost per diem for each of the five (5) arrays shall be based on the median number of patient days. The upper limit for each peer group containing facilities with more than 100 beds shall be computed at the median. The upper limit for each peer group of facilities with less than 101 beds shall be 110 percent of the weighted median. The upper limit for state designated teaching hospitals shall be established at 106 percent of the weighted median per diem for hospitals in their peer group. State teaching hospitals owned or operated by the University of Kentucky and

the University of Louisville hospitals shall be removed from the array in order to set the upper limit for other hospitals in the class. These state teaching hospitals shall be subject to the upper limits for facilities with 401 beds and up

Psychiatric hospitals shall not be peer grouped, but shall be in a separate array of psychiatric hospitals only.

Except as indicated in Section 101, the operating cost per diem and the capital cost per diem shall be limited to the prior year's rate per diem increased by 150 percent of the DRI average rate of inflation.

Section 102A. PAYMENT FOR CHILDREN WITH EXCEPTIONALLY HIGH COST OR LONG LENGTHS OF STAY

(a). CHILDREN UNDER AGE ONE (1)

For medically necessary hospital inpatient services provided to infants under the age of one (1) with exceptionally high cost or long lengths of stay, the payment shall be the same as item (b) of this section. These payments shall apply without regard to length of stay or number of admissions of the infants and regardless of whether they are in a disproportionate share hospital.

(b) CHILDREN UNDER AGE SIX (6) IN A DISPROPORTIONATE SHARE HOSPITAL

For medically necessary stays in disproportionate share hospitals, the allowable length of stay for children under age six (6) shall not be limited. After thirty (30) days from the date of admission (thirty (30) days from the date of the mother's discharge in the case of newborns), the facility shall be paid a per diem equal to 110 percent of their normal per diem. During the initial thirty (30) days the hospital shall be paid its normal per diem. The payment rate shall be based on the hospital's prospective rate in effect for the period billed.

Section 102B. DISPROPORTIONATE SHARE HOSPITALS

42 U.S.C. 1396r-4, as amended, imposed new requirements regarding payments to hospitals considered to be serving a disproportionate share of indigent individuals (i.e., the term "disproportionate share hospital"). This section of the manual specifies which hospitals shall be classified as disproportionate share, and the payment adjustment made with regard to them.

(a) Classification

(1) Disproportionate share hospitals shall be defined as those hospitals meeting the following criteria:

A. The hospital shall have at least two (2) obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to Medicaid eligible individuals. If the hospital is located in a rural area (that is, an area outside of a Metropolitan Statistical Area, as defined by the Executive Office of Management and Budget), the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.

B. Item A above shall not apply to a hospital if:

1. The inpatients are predominately individuals under eighteen (18) years of age; or

2. The hospital did not offer nonemergency obstetric services as of December 21, 1987.

C. In addition to the criteria in (A) and (B) of this section, the hospital shall have a Medicaid inpatient utilization rate of not less than one (1) percent to be considered as disproportionate share.

(b) The following upper limits and payment principles shall apply to disproportionate share hospitals:

(1) Acute care hospitals with Medicaid utilization of twenty (20) percent or higher, or having twenty-five (25) percent or more nursery days resulting from Medicaid covered deliveries as compared to the total number of allowable Medicaid days, shall have an upper limit set at 120 percent of the weighted median per diem cost for hospitals in the array. In addition

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(2) State university teaching hospitals having Medicaid utilization of twenty (20) percent or higher, or having twenty-five (25) percent or more nursery days resulting from Medicaid covered deliveries as compared to the total number of paid Medicaid days shall have an upper limit set at 126 percent of the weighted median per diem cost for hospitals of 401 beds or more. Any state designated pediatric teaching hospitals shall also be paid, in addition to the facilities' base rate, an amount which is equal to two (2) percent of the rate for each one (1) percent of Medicaid occupancy but this amount shall not exceed the prospective, reasonably determined uncompensated Medicaid cost to the facility. For the rate year ending June 30, 1999, any state designated state pediatric hospital further meeting the qualifications of a Type III hospital, instead of the above, shall be paid a supplemental payment in an amount equal to two (2) percent of the rate for each one (1) percent of Medicaid occupancy but this amount shall not exceed the Medicaid charges of the hospital. In addition to the per diem amount computed using the limits specified in this paragraph, the hospitals shall be paid, if appropriate, additional amounts for services to infants under age six (6) (as shown in Section 102A).

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(3) Psychiatric hospitals with Medicaid utilization of thirty-five (35) percent or higher shall have an upper limit set at 115 percent of the weighted median per diem cost for psychiatric hospitals in the array.

(4) All other disproportionate share acute care hospitals shall have their upper limit set at the weighted median per diem of the cost for hospitals in the array. In addition to the per diem amount computed in this manner, the hospitals shall be paid, if appropriate, an additional amount for services to infants under age six (6) (as shown in Section 102A).

A. Frequency of Review

Except as otherwise specified in this paragraph, classification of disproportionate share hospitals shall be made prospectively prior to the beginning of each universal rate year. Classification, once determined by the department, shall not be revised for that rate year except that for psychiatric hospitals not previously determined to meet disproportionate share hospital status due to failure to meet the one (1) percent minimum Medicaid occupancy requirement, the department shall also accept no more frequently than once each calendar year a patient census submitted by the

hospital showing adequate Medicaid occupancy with the subsequent classification to be effective for the balance of the calendar year.

(d) Disproportionate share hospital types shall be as follows:

(1) Type I hospitals shall be those in-state disproportionate share with 100 beds or less participating in the Medicaid program.

(2) Type II hospitals shall be those in-state disproportionate share hospitals with 101 beds or more, except for Type III and IV, participating in the Medicaid program.

(3) Type III hospitals shall be those in-state disproportionate share hospitals participating in the Medicaid program that have been designated as State university teaching hospitals and have made a request to the Department for Medicaid Services to be designated as a Type III hospital with the request subsequently approved by the department. As part of its designation as a Type III hospital, the hospital shall agree to provide up to 100 percent of the state's share of matching funds necessary to secure federal financial participation for Medicaid disproportionate share hospital payments to be made to the hospital during the period of time the hospital is classed as a Type III hospital;

(4) Type IV hospitals shall be those in-state disproportionate share hospitals participating in the Medicaid Program that are state-owned psychiatric hospitals.

(5) Type V hospitals shall be those out-of-state disproportionate share hospitals participating in the Medicaid program.

Section 102C. DISPROPORTIONATE SHARE HOSPITAL PAYMENTS

(a) The disproportionate share hospital payments for Type I and Type II hospitals shall be based on the cost of providing indigent care. Total disproportionate share payments to Type I and Type II hospitals for indigent care services provided during the 1997 fiscal year shall not exceed available funds; if payments cause the limits to be exceeded, all hospitals shall be adjusted proportionately. The funds shall be distributed to each qualifying hospital according to its proportion of costs to the total funds available for the year. The proportions shall be calculated by dividing the cost of each hospital's indigent care by the total cost of indigent care for all hospitals.

(b) The disproportionate share hospital payments for Type III hospitals and Type IV hospitals shall be equal to 100 percent of the cost of providing services to Medicaid patients, less the amount paid by Medicaid as usual Medicaid per diem payments, plus the cost of services to uninsured patients, less any cash payments made by the uninsured patients.

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(c) The disproportionate share hospital payments for Type V hospitals shall be one (1) dollar per Medicaid day plus an earned adjustment which is equal to ten (10) cents for each one (1) percent of Medicaid occupancy above one (1) standard deviation.

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Section 102D. PROVIDER TAXES

Provider taxes shall be considered an allowable cost with that portion attributable to Medicaid utilization included in the per diem rates.

Section 103. INFLATION FACTOR

After allowable costs have been trended to the beginning of the rate year, an indexing factor shall be applied to project inflationary cost in the universal rate year.

The inflation factor index to be used in the determination of the prospective rate shall be the inflation factor prepared by Data Resources Inc., forecasting in conjunction with relative weights developed by the Health Care Financing Administration (HCFA). The forecasted index represents the average inflation rate for the year and shall have general applicability to all participating hospitals.

The forecasted index utilized by the program shall remain in effect for the prospective rate year.

Adjustments shall not be made to the prospective rate if actual inflation differs from the projected inflation index.

Section 104. NEW PROVIDERS, CHANGE OF OWNERSHIP:

(a) CHANGE OF OWNERSHIP.

If a hospital undergoes a change of ownership, the new owner shall continue to be reimbursed at the prospective rate in effect. The new owner may appeal its rate subject to the provisions of Section 113. If at the time of the next prospective rate setting, the hospital does not have twelve (12) full months of actual costs in the fiscal year for which the cost report is submitted, the department shall use a partial fiscal year cost report to arrive at a prospective rate. This cost will be annualized and indexed appropriately.

(b) NEWLY CONSTRUCTED OR NEWLY PARTICIPATING HOSPITALS

Until a fiscal year end cost report is available, newly constructed or newly participating hospitals shall submit an operating budget and projected number of patient days within thirty (30) days of receiving Medicaid certification. A prospective rate shall be set based on this data, not to exceed the upper limit for the class. This prospective rate shall be tentative and subject to settlement at the time the first audited fiscal year end report is received from the Medicare intermediary. During the projected rate year, the budget can be adjusted if indicated, and justified

by the submittal of additional information.

(c) MERGED FACILITIES

In the case of two (2) separate entities that merge into one (1) organization, the Department for Medicaid Services shall merge the latest available data used for rate setting. Bed utilization statistics shall be combined, creating new occupancy ratios. Costs shall also be combined using the trending and indexing figures applicable to each entity in order to arrive at correctly trended and indexed costs. The rate of increase control (RIC) applicable to each entity shall be computed on a weighted average, based on the reported paid Medicaid days for each entity taken from the cost report previously used for rate setting. If one (1) of the entities merging has disproportionate status and the other does not, the merged entity shall retain the status of the entity which reported the highest number of Medicaid days paid. These merged per diem rates shall be subject to an appeals process. Finally, each provider shall submit a "Close of Business" Medicaid cost report for the period ended as of the day before the merger. This report shall be due from the provider within the time frame outlined in Section 109 of this manual. Medicaid cost reports for the period starting with the day of the merger and ending on

the day before the merger. This report shall be due from the provider within the time frame outlined in Section 109 of this manual. Medicaid cost reports for the period starting with the day of the merger and ending on the fiscal year end of the merged entity shall also be filed with the department in accordance with Section 109 of this manual.

Section 105. MINIMUM OCCUPANCY FACTOR

To assure that only program costs are compensated under this payment system and to encourage maximum occupancy, a minimum occupancy level shall be applied to Medicaid inpatient capital costs attributed to the program based on licensed beds available during the prior year.

(a) Hospitals with 100 or less licensed beds shall have a minimum occupancy factor of sixty (60) percent applied.

(b) Hospitals with 101 or more licensed beds shall have an occupancy factor of seventy-five (75) percent applied.

(c) Newly constructed hospitals shall be allowed one (1) full rate year before the minimum occupancy factor shall be applied.

Section 106. UNALLOWABLE COSTS

(a) The following costs shall not be considered allowable costs for Medicaid reimbursement:

(1) Costs associated with political contributions.

(2) The cost associated with legal fees for unsuccessful lawsuits against the cabinet. Legal fees relating to lawsuits against the cabinet shall only be included as a reimbursable cost in the period in which the suit is settled after a final decision has been made that the lawsuit is successful or if otherwise agreed to by the parties involved or ordered by the court; and

(3) The costs for travel and associated expenses outside the Commonwealth of Kentucky for purposes of conventions, meetings, assemblies, conferences or any related activities. However, costs (excluding transportation costs) for training or education purposes outside the Commonwealth of Kentucky shall be allowable costs. If these meetings are not educational, the cost (excluding transportation) shall be allowable if educational or training components are included.

(b) Since the costs in the referenced Section are currently not identified by the Medicare or Medicaid cost report, hospitals shall identify these unallowable costs on the Supplemental Medicaid Schedule KMAP-1. The Supplemental Medicaid Schedule KMAP-1 shall be completed and submitted with the annual cost report. The purpose of the Supplemental Medicaid Schedule KMAP-1 is to identify these unallowable costs for exclusion from the prospective rate computation.

Section 107. TRANSPLANTS

The program shall reimburse hospitals for transplants at the lessor of 80% of covered charges or a flat fee not to exceed $75,000. An exception to this limit may be made by the Commissioner, Department for Medicaid Services, on a case-by-case basis when the maximum payment limit restricts or prohibits the availability of the needed transplant procedure or service.

The costs associated with transplants shall not be included in allowable Medicaid costs. The charges and costs shall be reported in the total hospital charges and total hospital costs but shall not be included in the Medicaid charges or payments.

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Section 108. RETROACTIVE SETTLEMENTS

Revision of the prospective payment rate shall be made under the following circumstances:

(a) If incorrect payments have been made due to computational errors, i.e., mathematical errors, discovered in the cost basis or establishment of the prospective rate. Omission of cost data shall not constitute a computational error.

(b) If a determination of misrepresentation on the part of the facility is made by the program.

(c) If unaudited data is utilized to establish the universal rate, the rate shall be revised when the audited cost report is received from the fiscal intermediary or an independent audit firm under contract with the Department for Medicaid Services. If circumstances (a) or (b) occur, a settlement or revision shall be made only after the audited cost report is received from the fiscal intermediary. Factors which may affect the cost basis are costs utilized in determining Medicaid capital costs, i.e., total inpatient cost and total capital cost, and Medicaid allowable costs.

In accordance with Medicaid regulations at 42 CFR 447.271, Medicaid payments for inpatient hospital services shall be adjusted for the lesser of

total prospective payments or customary charges at the end of the prospective rate year. There shall be no allowance made under the prospective system for the carry forward provision utilized by Medicare (Title XVIII) in regard to the lesser of prospective payments or customary charges for inpatient services.

Section 109. COST REPORTING REQUIREMENTS

Each hospital participating in the Kentucky Medicaid Program shall submit an annual cost report, (HCFA 2552) including the Supplemental Medicaid Schedules, in the manner prescribed by the Medicaid Program. The cost report shall be submitted within five (5) months after the close of the fiscal year. An extension shall not be granted by the Medicaid Program. If the filing date lapses, the Program shall then suspend all payments to the facility until an acceptable cost report is received. The reports shall be filed for the fiscal year used by the facility.

Section 110. ACCESS TO SUBCONTRACTOR'S RECORDS

If the hospital has a contract with a subcontractor, e.g., pharmacy, doctor, hospital, etc., for services costing or valued at $10,000 or more over a twelve (12) month period, the contract shall contain a clause giving the department access to the subcontractor's books. Access shall also be allowed for any subcontract between the subcontractor and an organization related to the subcontractor.

Section 111. AUDIT FUNCTION

After the hospital has submitted the annual cost report, the program shall perform a limited desk review. The purpose of a desk review is to verify prior year cost to be used in setting the prospective rate. The Medicare intermediary shall be informed of any findings as a result of this desk review. Under a common audit agreement, the Medicare intermediary provides Medicaid with copies of any audits performed by Medicare (Title XVIII) and Medicaid (Title XIX) purposes. However, the program may choose to audit even though Medicare does not.

Section 112. DUAL LICENSED AND SWING BEDS

(a) DUAL LICENSED BEDS

Effective January 1, 1997, the department shall no longer reimbursedual licensed beds in hospitals.

(b) SWING BEDS

Federally defined swing beds shall be reimbursed by the program at the weighted average payment rate for routine services for the prior calendar year for all nursing facilities (excluding intermediate care facilities for the mentally retarded and developmentally disabled) in the state, depending on the level of care requirements of the patient in the swing bed.

(c) ANCILLARY SERVICES FOR DUAL LICENSED AND SWING BEDS

Payments for reimbursable ancillary services provided to nursing patients in dual licensed or swing beds shall be based on a facility-specific cost-to-charge ratio with a settlement to actual cost at the end of the facility's fiscal year. Ancillary services covered shall be the same ancillary services as are covered in the regular nursing care setting.

At the end of each facility's fiscal year a KMAP-2 and a KMAP-3

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shall be filed with the cost report. The Medicaid Program shall make a final settlement on the ancillary services provided to patients in dual licensed beds. A separate KMAP-2 and KMAP-3 should be completed for each level of care. For swing bed, the usual Medicare cost report forms shall be completed.

Section 113. REIMBURSEMENT REVIEW APPEAL PROCESS

A. Pursuant to 42 CFR 447.253(e), the department provides the following appeals procedure for a review of an individual hospital's rate limited to the following:

1. Increased costs related to allowable inpatient cost centers resulting from a capital expenditure requiring a certificate of need;

2. Increased costs related to allowable inpatient cost centers resulting from a capital expenditure not requiring a certificate of need meeting a qualifying determining amount of at least twenty-five (25) percent of its total fixed assets as reported on Worksheet G, Line 21 of its base year Medicare cost report; and

3. A mathematical or clerical error by the department.

B. The costs that represent the subject matter of an appeal shall increase the current per diem rate by at least five (5) percent in order for any relief to be granted.

C. A request for an administrative appeal under this section shall be in accordance with the following:

1. The certificate of need for the equipment that is the subject matter of the appeal must have been placed in service during the state fiscal year immediately preceding the rate year under appeal.

2. The following shall be included in the appeal request by the provider:

a. Documentation that demonstrates that the costs related to the certificate of need have not been built into the rate;

b. Operating and capital costs related to certificate of need for capital expenditure or capital costs related to a capital expenditure not requiring a certificate of need provided on a per diem basis as follows:

1.) For a capital expenditure not requiring a certificate of need and used for the provision of inpatient services only, the total costs of the capital expenditure shall be divided by total allowable patient days to determine the *costs per day*.

2.) For a capital expenditure requiring a certificate of need and used for the provision of inpatient services only, the total costs of the capital expenditure shall be divided by total allowable patient days to determine the *costs per day*.

3.) For a capital expenditure not requiring a certificate of need and for a capital expenditure requiring a certificate of need, that shall be used for inpatient and outpatient hospital services, the per diem costs shall be calculated by adjusting for outpatient utilization through an adjusted patient day calculation as follows:

a.) Total allowable inpatient revenues shall be divided by total allowable inpatient days to determine the *inpatient revenue per day*;

b.) Total outpatient revenues shall be divided by inpatient revenue per day to determine *outpatient equivalent days*;

c.) Inpatient days and outpatient equivalent days determined in accordance with 3.a. and 3.b. of this section shall be added to determine *adjusted patient days*; and

d.) Adjusted patient days shall be divided by total costs to determine *costs per day*.

3. Total patient days shall be the total patient days submitted on the base year Medicare cost report on Worksheet S-3, Column 6, excluding nonallowable cost centers.

4. Total inpatient revenue shall be the total inpatient revenue submitted on the base year Medicare cost report on Worksheet G-2, Column 1, Line 25, less nonallowable cost centers.

5. Total outpatient revenue shall be the total outpatient revenue submitted on the base year Medicare cost report on Worksheet G-2, Column 2, Line 25, less nonallowable cost centers.

6. Operating costs shall include salaries associated with additional full time equivalents (FTE) added as a result of the certificate of need.

7. Costs calculated in accordance with 2b. of this section shall be the only adjustments to be considered by the department to the applicable operating and capital components of a hospital's per diem rate.

8. The department shall adjust any relief granted under this section to the extent the relief is based on unaudited data, once the department is in possession of final audited data.

Section 114. PSYCHIATRIC HOSPITALS SUPPLEMENTS

Psychiatric hospitals shall be reimbursed in accordance with this reimbursement manual for hospital inpatient services, except as specified in this supplemental section.

(a) MAXIMUM PAYMENT

The upper limit shall be established at the weighted median of the array of allowable costs for all participating psychiatric hospitals, except that disproportionate share hospitals, as defined in this Section, shall have a payment rate calculated in accordance with Section 102A.

(b) DISPROPORTIONATE SHARE HOSPITALS

Psychiatric hospitals which qualify as disproportionate share hospitals are classified, as appropriate, as the various types shown in Section 102C of this manual.

(c) MEDICAID UTILIZATION

Hospitals having a Medicaid utilization of thirty-five (35) percent or

higher shall have an upper limit established at one-hundred and fifteen (115) percent of the weighted median.

(d) OCCUPANCY FACTOR

A minimum occupancy level will be imposed relative to Medicaid inpatient capital cost as outlined in Section 105.

(e) DEPRECIATION

Medicaid inpatient capital costs will be based on Medicare cost finding principles including full allowance for depreciation cost.

(f) CONTRACTUAL INPATIENT SERVICES

A psychiatric hospital designated by the cabinet as a primary referral and services resource for children in the custody of the Cabinet for Families and Children shall be exempt from the upper limit for the array and shall be paid at the actual projected cost with no year end settlement to actual cost; the projected cost may be adjusted for usual DRI cost of living increases.

Section 115. HOSPITAL INDIGENT CARE REPORTING REQUIREMENTS

All hospitals shall report monthly data on a quarterly basis the care provided to indigent individuals and families as defined in state law, including care provided to indigent persons age twenty-two (22) to sixty-four (64) in a psychiatric hospital, excluding nonemergency care provided through a hospital emergency room.

Section 116. DEFINITIONS

The following terms are used throughout the manual and are defined in the following context.

(a) Allowable inpatient operating cost per diem – the allowable inpatient operating cost computed as a per diem amount after exclusion of unallowable operating costs and applications of upper limits.

(b) Base rate – The sum of the allowable inpatient operating cost per diem, the allowable capital cost per diem, and the allowable professional component cost per diem.

(c) Base year – The base year is the facility's fiscal year used for setting a rate. Under this system, payment to hospitals is determined prospectively by establishing a base year cost for the hospital. The base year cost for the hospital is the latest available Medicaid cost report data trended to the beginning of the universal rate year using the Data Resources, Inc. trend factor.

(d) Cost basis – Cost basis refers to the total allowable Medicaid inpatient costs incurred by the provider in the base year.

(e) Universal rate year – The universal rate year, under the prospective payment system is the year beginning January 1 for which payment rates are established for all hospitals for a calendar year regardless of the hospital's fiscal year end.

(f) University teaching hospital – A hospital is designated to be a university teaching hospital is owned or operated by a university with a medical school.

(g) Low income utilization rate – For a hospital, the sum (expressed as a percentage) of the fraction, calculated as follows:

(1) Total Medicaid inpatient revenues paid to the hospital, plus the amount of the cash subsidies received directly from State and local governments in a cost reporting period, divided by the total amount of revenues of the hospital for inpatient services (including the amount of the cash subsidies) in the same cost reporting period; and

(2) The total amount of the hospital's charges for inpatient services attributable to charity care (care provided for individuals who have no source of payment, third-party or personal resources) in a cost reporting period, less the portion of any cash subsidies for patient

services received directly from the State and local governments in the period attributable to inpatient hospital services, divided by the total amount of the hospital's charges for inpatient services in the hospital in the same period. The total inpatient charges attributed to charity care shall not include contractual allowances and discounts (other than for indigent patients not eligible for Medicaid) that is, reductions in charges given to other third party payers, such as HMOs, Medicare or Blue Cross, etc.

Section 117. SUPPLEMENTAL MEDICAID SCHEDULES AND INSTRUCTIONS

This section contains the supplemental Medicaid schedules and instructions used for hospital rate setting purposes.

TN # 97-03
Supersedes
TN 95-11

Approval Date DEC 21 2000

Effedtive Date: 1/01/97

INSTRUCTIONS FOR SUPPLEMENTAL MEDICAID SCHEDULE

KMAP-1

NOTE: FOR HCFA-2552-92 (11-92)

ine 1 – Enter amount paid as legal fees associated with lawsuits brought against the Cabinet for Human Resources. (See " Medicaid Reimbursement Manual for Hospital Inpatient Services", Section 106(a)(2).

ine 2 – Enter all expenses associated with political contributions.

ine 3 – Enter all expenses associated with travel outside the Commonwealth.

ine 4 – Sum of lines 1, 2, and 3.

olumn 3 Enter amounts from HCFA-2552-92, Worksheet B, Part I, Column 25 on the appropriate lines, as indicated. Note that Line 11A and 11B are taken from Worksheet D-2 as indicated, and the total of these two should equal the amount of Worksheet B, Part I, Line 70.

Line 13 – Enter sum of lines 5 through 12.

Line 14 – Enter amount from line 4.

Line 15 – Divide the non-allowable cost on line 14 by the total cost on line 13 and enter answer.

olumn 4 Lines 5 through 12. Multiply the ratio from line 15 by each amount entered on lines 5 through 12 and enter answers on the appropriate line of column 4.

Line 13 – Enter sum of line 5 through 12. Sum in column 4, line 13 should equal the non-allowable cost on Line 4.

Line 16 – Enter only the sum of Lines 5A, 6, and 10A. Line 5B should only be included if the cost is applicable to a psychiatric or rehabilitation unit.

Line 17 – Divide the Medicaid Inpatient Allowable Cost (HCFA-2552-92, 11/92, Worksheet E-3, Part III, Total of Lines 1 through 5 plus 5A) by the Total Inpatient Allowable Cost (HCFA-2552-92), Worksheet B, Part I, Column 25. Total expenses less amounts on Line 60 through to total expenses with exception of Line 70 which should be included in Total Inpatient Allowable Cost.

Line 18 – Multiply the amount entered on Line 16 by the ratio on Line 17 to determine the Medicaid portion of the non-allowable cost.

Line 19 – Deduct the amount entered on Line 18 from the Medicaid Inpatient Allowable Cost (HCFA-2552-92, Worksheet E-3, Part III, Line 6).

Line 20 – Enter only the sum of the amount of non-allowable cost from Lines 7 and 10B.

Line 21 – Divide Medicaid Outpatient Allowable Cost (HCFA-2552-92, Worksheet E-3, Part III, Column 2, Line 6) by the Total Outpatient Allowable Cost (HCFA-2552-92) Worksheet B, Part I, Column 25, Lines 60 through 63.

Line 22 – Multiply the ratio from Line 21 by the amount from Line 20.

Line 23 – Deduct the amount on Line 22 from the amount entered on Worksheet E-3, Part III, Column 2, Line 6.

SUPPLEMENTAL MEDICAID SCHEDULE I

Computation of Legal Fees, Political Contributions, and Out-of-State travel not Allowable to Medicaid Services

Legal Fees _____
Political Contributions _____
Out-of-State Travel _____
Total Non-Allowable Cost _____

HOSPITAL _____
VENDOR NO _____
PERIOD FROM _____
PERIOD TO _____

Column 1	Column 2	Column 3	Column 4
COST CENTERS	From Medicare Cost report Worksheet B	Accumulated Cost	Allocated Non-Allowable Costs
Inpatient routine Service A. Hospital	Total of Lns. 25-30 & 33		
B. Sub Providers (other than Inpatient Hospital)	Lns. 31,32, 34-36		
Ancillary Service Cost Center	Total of Lines 37-59		
Outpatient Service Cost Centers	Tot Lns. 60-63		
Home Program Dialysis	Ln. 64		
Ambulance Services	Ln. 65		
)A. Intern-Res. Srvc. Not Appr. (I/P) D-2, Ln. 19, Col. 2*	Ln. 70		
)B. Intern-Res. Srvc. Not Appr. (O/P) D-2, Line 23, Col. 2*			
l. Other Cost Centers	Ln. 71-94		
2. Non-Reimbursable Cost Centers	Tot. Lns. 96-103		
1. Total Expenses (Sum of Lns. 5-12)			
4. Total Non-Allowable Costs (Line 4)			
5. Unit Cost Multiplier (Ln. 14 / Ln. 13)			
6. Non-Allowable Cost Applicable to Inpt. Costs			
7. Medicaid Inpatient Allowable Cost (Supplemental Worksheet E-3, Part III. Total of Lns. 1 thru 6 plus 7b, excluding all outpt.) divided by the total Inpt. allowable hospital cost (Worksheet B, Part I) See Instructions Attached			
8. Medicaid Non-Allowable Cost Line 16 X Line 17			
9. Medicaid Allowable Cost. Deduct the amount entered on Line 18 from the Medicaid Services Inpatient Cost on E-3 Part III, Col 1, Line 6			
OUTPATIENT			
0. Non-Allowable cost applicable to outpatient cost from line 7 and 10B.			
1. Determination of Medicaid Non-allowable Cost. (See Instructions Attached)			
2. Medicaid Non-Allowable Outpatient Cost. (Line 20 X Line 21)			
3. Medicaid Allowable Outpatient Cost. Deduct the amount entered on Line 22 from the Medicaid Services Outpatient Cost on E-3 Part III Col 2 Line 6			

Costs are broken between Inpatient and Outpatient Departments on W/sheet D-2

State Kentucky

COMPUTATION OF DUAL LICENSED ANCILLARY COST

HOSPITAL VENDOR NUMBER _____

ICF DUAL LICENSED PROVIDER NUMBER _____
SNF DUAL LICENSED PROVIDER NUMBER

ANCILLARY COST CENTERS	TOTAL ANC. COST COL. 1	TOTAL DIRECT COST COL. 2	DIRECT COST % COL.3 (2/1)	TOTAL INDIR. COST COL. 4	INDIR. COST % COL. 5 (4/1)	RATIO OF COST TO CHG COL.6	DIRECT COST TO CHG RATIO COL. 7 (6X3)	MEDICAID DUAL INPATIENT CHARGES (BILLED) COL. 8	INPATIENT DIRECT COST COL. 9 (7X8)	INDIRECT COST TO CHG. RATIO COL. 10 (6 X 5)	MEDICAID DUAL CHARGE (BILLABLE & NON-BILLABLE UNDER SNF) COL. 11	INPATIENT INDIRECT COST COL. 12 (10 X 11)
41 RADIOLOGY-DIAGNOSTIC												
42 RADIOLOGY-THERAPEUTIC												
43 RADIOISOTOPE												
44 LABORATORY												
45 PBP CLINIC LAB SVC-PRG. ONLY												
46 WHOLE BL. & PK. RED BL. CELLS												
48 IV THERAPY												
49 RESPIRATORY THERAPY												
51 OCCUPATIONAL THERAPY												
53 ELECTROCARDIOLOGY												
54 ELECTROENCEPHALOGRAPHY												
55 MED. SUPPLIES CHG. TO PT.												
56 * DRUGS CHARGED TO PATIENTS												
101 TOTAL												

104 AMOUNT RECEIVED FROM THE MEDICAID PROGRAM (FROM PROGRAM PAID CLAIMS LISTING)

105. AMOUNT DUE PROGRAM/PROVIDER (LINE 101, COL. 9 LESS LINE 104)

INSTRUCTIONS

1. TOTAL ANCILLARY COSTS FROM HCFA-2552-89, WORKSHEET C, COLUMN 3
2. ALL COST ALLOWABLE UNDER MEDICAID IC/SNF RULES AS DIRECT COST
3. COLUMN 2 DIVIDED BY COLUMN 1
4. ALL OTHER ANCILLARY COST (COLUMN 1 LESS COLUMN 2)
5. COLUMN 4 DIVIDED BY COLUMN 1
6. RATIO OF COST TO CHARGES FROM HCFA-2552-92, WORKSHEET C, COL. 8
7. COLUMN 6 MULTIPLIED BY COLUMN 3
8. DUAL LICENSED CHARGES BILLED TO THE MEDICAID PROGRAM
9. COLUMN 7 MULTIPLIED BY COLUMN 8
10. COLUMN 6 MULTIPLIED BY COLUMN 5
11. ALL DUAL LICENSE CHARGES INCLUDING THOSE CHARGES BILLABLE AND NON-BILLABLE TO THE MEDICAID IC/SNF PROGRAM. SHOULD NOT INCLUDE THOSE CHARGES CONSIDERED TO BE NON-ALLOWABLE COST FOR SERVICES IN A LONG TERM CARE SETTING
12. COLUMN 10 MU[illegible]PLIED BY COLUMN 11. TRANSFER THIS AMOUNT TO KMAP-3, LINE 13

* COST AND C[illegible]GES PRIOR TO OCTOBER 1, 1990 ONLY

Approval Date DEC 21 1998 Effective Date 1-1-97

TN No. 97-03
Supersedes
TN No. 95-11

KMAP-3

SUPPLEMENTAL MEDICAID SCHEDULE

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR DUAL LICENSED BEDS

HOSPITAL _____

VENDOR # _____

PERIOD FROM _____ PERIOD TO _____

1.	Dual-licensed NF-type Medicaid inpatient days	
2.	Dual-licensed SNF-type Medicaid inpatient days	
3.	Dual-licensed ICF-type Medicaid inpatient days	
4.	Medicaid rate for dual-licensed NF bed services	
5.	Medicaid rate for dual-licensed SNF bed services	
6.	Medicaid rate for dual-licensed ICF bed services	
7.	Medicaid payments for dual-licensed NF-type services (Line 1 x Line 4)	
8.	Medicaid payments for dual-licensed SNF-type services (Line 2 x Line 5)	
9.	Medicaid payments for dual-licensed ICF-type services (Line 3 x Line 6)	
10.	Total Medicaid payments for dual-licensed services (Line 7 + Line 8 + Line 9)	
11.	Total Medicaid dual licensed inpatient routine service cost	
12.	Medicaid dual licensed inpatient routine service cost net of dual-licensed payments (Line 11 – Line 10)	
13.	Indirect cost for ancillary services rendered to dual-licensed patients	
14.	Total unreimbursed Medicaid dual license inpatient service cost (Line 12 + Line 13)	

INSTRUCTIONS

Line #

1. From the Medicaid program's Paid Claims Listings
2. From the Medicaid Program's Paid Claims Listings
3. From the Medicaid Program's Paid Claims Listings
13. Transfer from KMAP-2 Line 101, Column 12
14. Line 12 plus line 13.

* Effective for services provided after October 1, 1990

SUPPLEMENTAL MEDICAID SCHEDULE 4

FACILITY:

FYE:

VENDOR NUMBER:

a. Did your facility offer nonemergency obstetric services as of December 21, 1987? (ANSWER YES "ONLY" IF THERE WERE "AT LEAST" 2-OB'S OR PHYSICIANS WHO OFFERED NON-EMERGENCY OBSTETRIC SERVICES.)

Yes _____
No _____

b. Does your facility predominantly serve individuals under 18 years of age?

Yes _____
No _____

If yes, indicate the percent of the individuals under 18 years of age.

% _____

c. Does your facility have at least two obstetricians with staff privileges who have agreed to provide obstetric services to Medicaid eligible individuals? In the case of a hospital located in a rural area (that is an area outside a Metropolitan Statistical Area), the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.

Yes _____
No _____

2. Enter the total Medicaid inpatient revenues (payments) paid to your facility, plus the amount of cash subsidies received directly from state and local governments.

$ _____

3 Enter the total inpatient revenues (payments) paid to your facility, plus the amount of cash subsidies received directly from state and local governments.

$ _____

4. Enter the total amount of the facility's charges for inpatient hospital services attributable to charity care (care provided to individuals who have no source of payment, third-party or personal resources).

The total inpatient charges attributed to charity care should not include bad debts or contractual allowances and discounts (other than for indigent patients not eligible for Medicaid), that is, reductions in charges given to other third party payers, such as HMOs, Medicare or Blue Cross.

The charges should be net of any cash subsidies for patient services received directly from state and local governments in the period attributable to inpatient hospital services.

$ _____

5 Enter the total amount of the facility's charges for inpatient services.

$ _____

The above statements are accurate and correct to the best of my knowledge.

Signed: _____
President, Administrator, or Chief Financial Officer

SUPPLEMENTAL WORKSHEET 5

(MEDICAID SERVICES DEPRECIATION)

HOSPITAL _____
VENDOR # _____
PERIOD FROM _____ PERIOD TO _____
REASON FOR REVISION _____

A. INSTRUCTIONS

B. CAPITAL COST COMPUTATION

1A. TOTAL CAPITAL COST (W/S B, PART II + B PART III COLUMN 4A – LINE 95) LESS NON-ALLOWABLE COST CENTERS) LESS INTEREST/INSURANCE/TAXES (RELATED TO CAPITAL COST W/S A-7 PART III) = ADJUSTED TOTAL CAPITAL COST.

LINE 1B. | | | |

2A. ADJUSTED TOTAL CAPITAL COST (LINE1) / TOTAL CAPITAL COST = RATIO.

LINE 2B. | | | |

3A. RATIO (LINE 2) X MEDICAID SERVICES CAPITAL COST (ROUTINE AND ANCILLARY W/S D, PARTS I AND II = ADJUSTED MEDICAID SERVICES CAPITAL COST (MEDICAID SERVICES CAPITAL COST LESS INT./INS./TAXES).

LINE 3B. | | | |

4A. TOTAL BLDG. AND FIXTURES / TOTAL CAPITAL COST = RATIO
(W/S B, PART II & B PART III COL. 1 & 3 LINE 95) LESS NON-ALLOWABLE COST CENTERS)
(W/S B PART II & B PART III 4A. LINE 95 LESS NON-ALLOWABLECOST CENTERS)
(RATIO OF BLDG. AND FIXTURES TO TOTAL CAPITAL COST).

LINE 4B. | | | |

5A. RATIO (LINE 4) X MEDICAID SERVICES ADJUSTED CAPITAL COST (LINE 3) = MEDICAID SERVICES BLDG. AND FIXTURES .

LINE 5B. | | | |

6A. MEDICAID SERVICES CAPITAL COST LESS MEDICAID SERVICES BLDG.& FIXTURES (LINE 5) = MEDICAID SERVICES MOVABLE EQUIP. AND INTEREST/ INSURANCE / TAXES.

LINE 6B. | | | |

7A. 65% X MEDICAID SERVICES BLDG .& FIX. (LINE 5) = ALLOWABLE MEDICAID SERVICES BLDG. & FIXTURES

LINE 7B. | 0.65 | | |

8A. MEDICAID SERVICES EQUIPMENT AND INTEREST/INSURANCE/TAXES (LINE 6) + MEDICAID SERVICES ALLOWABLE BLDG. & FIXTURES (LINE 7) = MEDICAID ALLOWABLE INPATIENT CAPITAL COST

Line 8B. | | | |

SUPPLEMENTAL MEDICAID SCHEDULE 6

'ROFESSIONAL COMPONENT/LABOR-DELIVERY ROOM DAYS/NURSERY INFORMATION

HOSPITAL _____
VENDOR NUMBER _____
PERIOD FROM _____
PERIOD TO _____

AUDITOR _____
DATE _____
REVIEWER _____
DATE _____

\. HOSPITAL-BASED PROFESSIONAL COMPONENT SERVICES

:OST CENTERS	Col. 1 TOTAL PROFESSIONAL COMPONENT CHG. INPATIENT	Col. 2 TOTAL MEDICAID SERVICES PROFESSIONAL COMPONENT CHG. INPATIENT	Col. 3 TOTAL PROFESSIONAL COMPONENT CHG. OUTPATIENT	COL. 4 TOTAL MEDICAID SERVICES PROFESSIONAL COMPONENT CHG OUTPATIENT
\NESTHESIOLOGY				
\ADIOLOGY-DIAGNOSTIC				
\ADIOLOGY-THERAPEUTIC				
\ADIOSOTOPE				
ABORATORY				
:KG				
:EG				
3LANK				
3LANK				
:MERGENCY ROOM				

VHEN PROFESSIONAL COMPONENT SERVICES ARE INCLUDED IN THE COST REPORT, A SUPPLEMEN-
'AL WORKSHEET D-3 SHOULD BE COMPLETED. ALSO, THIS OFFICE MUST RECEIVE THIS SUPPLEMENTAL
3CHEDULE IDENTIFYING, BY COST CENTERS, THE TOTAL PROFESSIONAL COMPONENT CHARGES
\NC : MEDICAID SERVICES PROFESSIONAL COMPONENT CHARGES.

3. LABOR/DELIVERY ROOM DAYS

)OES TOTAL HOSPITAL ADULT AND PEDIATRIC DAYS (EXCLUDING SWING BEDS) ON WORKSHEET
3-3 (HOSPITAL STATISTICAL DATA) LINE 1.01, COLUMN 6 INCLUDE LABOR/DELIVERY ROOM
lays.

YES _____ NO _____

F NO, PLEASE INDICATE TOTAL LABOR/DELIVERY ROOM DAYS. _____

2. NURSERY DAYS

PLEASE INDICATE THE FOLLOWING:

1. THE NUMBER OF MEDICAID NURSERY DAYS FROM WORKSHEET S-3, COLUMN 5 THAT ARE PAID AT AN AMOUNT GREATER THAN ZERO. _____

2. THE NUMBER OF MEDICAID NURSERY DAYS ON WORKSHEET S-3, COLUMN 5 THAT ARE ZERO PAID. _____

3. THE NUMBER OF MEDICAID NEONATAL NURSERY DAYS FROM WORKSHEET S-3, COLUMN 5 THAT ARE PAID AT AN AMOUNT GREATER THAN ZERO. _____

4. THE NUMBER OF MEDICAID NEONATAL NURSERY DAYS FROM WORKSHEET S-3, COLUMN 5 THAT ARE ZERO PAID. _____

SUPPLEMENTAL MEDICAID SCHEDULE 8

COMPUTATION OF EXCLUDED ALLOWABLE

PROFESSIONAL COST WHICH IS NOT REIMBURSABLE

BY MEDICAID SERVICES ON WORKSHEET D-3

AC. _____

ENDOR #: _____ PERIOD FROM _____ PERIOD TO _____

COL. 1 Cost Centers	COL. 2 Cost From Wk/S A-8 or A-8-2
. CRNA	
. Physical Therapist	
. Respiratory Therapist	
. Clinic	
. Other	
. Total	

. Determine a ratio of Hospital Inpatient Cost to total Hospital Cost _____

. Determine a ratio of Hospital Outpatient Cost to total Hospital Cost _____

. Multiply the ratio from Line 7 & Line 8 by the total amount entered on line 6 to determine the cost applicable to Inpatient and Outpatient services.
   a. Inpatient Cost (Excluded Allowable Professional Cost) _____
   b. Outpatient Cost (Excluded Allowable Professional Cost) _____

0. . mine the ratio of Medicaid Services Inpatient Cost to total Inpatient Cost _____

1. Determine the ratio of Medicaid Services Outpatient Cost to total Outpatient Cost _____

2. Multiply the ratio of Medicaid Services Inpatient Cost Line 10 by the amount entered on line 9a for Medicaid Services Inpatient Cost. Enter the amount on Wkst. E-3 Part III, Line 5a, Col. 1. _____

3. Multiply the ratio of Medicaid Services Outpatient Cost Line 11 by the amount entered on line 9b for Medicaid Services Outpatient Cost. Enter the amount on Wkst. E-3 Part III, Line 5a, Col.2. _____

INSTRUCTIONS

LINE #

7. Divide the sum of Worksheet B, Part I, col. 25, lines 25 through 33, lines 37 through 59, and line 70 by the sum of Worksheet B, Part I, col. 25, line 103.

8. Divide the sum of Worksheet B, Part I, col. 25, lines 60 through 63 by the sum of Worksheet B, Part I, col. 25, line 103.

10. Divide the amount of Medicaid Services Inpatient cost (HCFA 2552-92,11/92, E-3, Part III, Col. 1 Total of lines 1 through 5) by the Total Hospital Inpatient Cost (Sum of Worksheet B, Part I, col. 25 lines 25 through 33, lines 37 through 59, and line 70).

11. Divide the amount of Medicaid Services Outpatient cost (HCFA 2552-9292, 11/92, E-3 Part III, Col. 2 Total of lines 1 through 5 PLUS LAB COST (D PART V) by the Total Hospital Outpatient Cost (Sum of Worksheet B, Part I col. 25, lines 60 through 63).